

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048636

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 385

Primary Registration District No. 3038

Registrar's No.

FILED DEC 26 1963

VS 300  
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>LINN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>CHARITAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BROOKFIELD</b>		Length of stay in 1b <b>2 YRS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BROOKFIELD NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM J. METCALF</b>		4. DATE OF DEATH Month Day Year <b>12-16-63</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	
11. BIRTHPLACE (City and state or country) <b>SUMNER, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>ROBERT H. METCALF</b>		13b. MOTHER'S MAIDEN NAME <b>MARY TAYLOR</b>	
14. NAME OF HUSBAND OR WIFE <b>ANNA</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS CHAS. FOSTER, LACLEDE, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Diagnosed arteriosclerosis.</b> DUE TO (c) <b>Sclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22-5-7</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Sclerosis.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>SUMNER, MISSOURI</b>		
21. I attended the deceased from <b>22-11-63</b> to <b>11-8-63</b> and last saw her alive on <b>11-8-63</b> . Death occurred at <b>22-11-63</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. W. Roberts M.D.</b>		22b. ADDRESS <b>Brookfield Mo.</b>	
22c. DATE SIGNED <b>12/18/63</b>		22d. DATE SIGNED <b>12/18/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-18-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKESIDE CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>SUMNER, MISSOURI</b>		23e. DATE RECD. BY LOCAL REG. <b>12-18-63</b>	
23f. REGISTRAR'S SIGNATURE <b>Anna Watson</b>		23g. FUNERAL DIRECTOR <b>WRIGHTS</b>	
23h. ADDRESS <b>LACLEDE, Mo.</b>		23i. DATE RECD. BY LOCAL REG. <b>12-18-63</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DEC 30 1963

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed C. H. Knight

Licensed Embalmer No. 5167

P. O. Address Brookfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.